3.2 Covered Benefits and Limitations

3.2.1 Overview – Rule 12/01/1998

This section lists the various dental services covered by Medicaid with specific limitationsand exclusions.

- Diagnostic procedures
- Preventive procedures
- Restorative procedures
- Endodontics
- Periodontics
- Prosthodontics
- Oral surgery
- Orthodontics
- Adjunctive general services
- Services provided to clients of the Pregnant Women and Children (PWC) program

3.2.2 Diagnostic Procedures 00110 — 00999 – Rule 12/01/1998

The following examinations are not allowed in combination on the same day:

Service	Dental Code	Description	Effective Rule Date
GENERAL ORAL EVALUATIONS			
	00120	Periodic oral evaluation. One periodic examination is allowed every six months.	12/01/1998
	00140	Limited oral evaluation. An evaluation or re-evaluation limited to a specific oral health problem.	12/01/1998
	00150	Comprehensive oral evaluation. One comprehensive examination is allowed every 12 months. Six months must elapse before a periodic exam can be paid.	12/01/1998
	00160	Detailed and extensive oral evaluation. A detailed and extensive problem focused evaluation that entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. One detailed and extensive oral evaluation is allowed every 12 months.	12/01/1998

TN # 98-002
SUPERSEDES TN # N/A
DATE APPROVED 5/20/99
EFFECTIVE DATE 12/1/98
DATE TO C.O.

Service	Dental Code	Description	Effective Rule Date
RADIOGRAPHS			
	00210	Intraoral — complete series (including bitewings). Complete series x-rays are allowed only once in a three-year period. A complete intraoral series consists of 14 periapicals and one series of four bitewings.	12/01/1998
	00220	Intraoral periapical — first film.	12/01/1998
	00230	Intraoral periapical — each additional film.	12/01/1998
	00240	Intraoral occlusal film.	12/01/1998
	00270	Bitewing — single film. Total of four bitewings allowed every six months.	12/01/1998
	00272	Bitewings — two films. Total of four bitewings allowed every six months.	12/01/1998
	00274	Bitewings — four films. Total of four bitewings allowed every six months.	12/01/1998
	00330	Panoramic film. Panorex, panelipse or orthopantograph are also allowed under this code. Panoramic-type films are allowed once in a 12-month period. This time limitation does not apply to preoperative or postoperative surgery cases. Doing both a panoramic film and an intraoral complete series is not allowed. Up to four bitewings are allowed in addition to a panoramic film.	12/01/1998
	00340	Cephalometric film. Allowed once in a 12-month period.	12/01/1998
TEST AND LABORATORY EXAMINATION			
	00460	Pulp vitality test. Tooth designation required.	12/01/1998
	00470	Diagnostic casts.	12/01/1998
	00501	Histopathologic examinations.	12/01/1998
DIAGNOSTIC			
	00999	Unspecified diagnostic procedure, by report. Narrative required when prior authorizing.	12/01/1998

3.2.3 Preventive Procedures 01000 — 01999 – Rule 12/01/1998

Medicaid provides no additional allowance for a cavitron or ultrasonic prophylaxis.

Service	Dental Code	Description	Effective Rule Date
DENTAL PROPHYLAXIS			
	01110	Prophylaxis — Adult (12 years of age and older). A prophylaxis is allowed once every six months.	12/01/1998
	01120	Prophylaxis — Children/young adult (up to age 12). A prophylaxis is allowed once every six months.	12/01/1998
FLUORIDE TREATMENTS			
	01203	Topical application of fluoride — one treatment (excluding prophylaxis). Allowed once every six months for clients under 21.	12/01/1998
	01204	Topical application of fluoride — adult, over 21 years of age. Allowed once every six months.	12/01/1998
OTHER PREVENTIVE SERVICES			
	01351	Sealant — per tooth. Allowed for clients 0-21 years of age. Limited to once per tooth every three years.	12/01/1998
SPACE MANAGEMENT THERAPY: Space maintainers are allowed to hold space for missing teeth for clients under age 21. No reimbursement is allowed for removing maintainers, unless by dentist other than providing dentist. Vertical space maintainers are not covered.			
	01510	Space maintainer — fixed — unilateral. Limited up to age 21. Only allowed once per tooth space. Tooth space designation required	12/01/1998
	01515	Space maintainer — fixed — bilateral. Limited up to age 21. Only allowed once per arch. Arch designation required.	12/01/1998
	01520	Space maintainer, removable — unilateral. Allowed once every two years up to 21 years of age. Tooth space designation required.	12/01/1998
	01525	Space maintainer, removable — bilateral. Allowed once every two years up to 21 years of age. Tooth space designation required.	12/01/1998
	01550	Recementation of space maintainer. Limited up to age 21. Only allowed once per quadrant or arch. Quadrant or arch designation required.	12/01/1998

3.2.4 Restorative Procedures 02000 — 02999 – Rule 12/01/1998

3.2.4.1 Posterior Restoration – Rule 12/01/1998

A one-surface posterior restoration is one in which the restoration involves only one of the five surface classifications (mesial, distal, occlusal, lingual, or facial).

A two-surface posterior restoration is one in which the restoration extends to two of the five surface classifications.

A three-surface posterior restoration is one in which the restoration extends to three of the five surface classifications.

A four or more surface posterior restoration is one in which the restoration extends to four or more of the five surface classifications.

3.2.4.2 Anterior Proximal Restoration – Rule 12/01/1998

A one-surface anterior proximal restoration is one in which neither the lingual nor facial margins of the restoration extends beyond the line angle. A two-surface anterior proximal restoration is one in which either the lingual or facial margin of the restoration extends beyond the line angle.

A three-surface anterior proximal restoration is one in which both the lingual and facial margins of the restorations extend beyond the line angle.

A four or more surface anterior restoration is one in which both the lingual and facial margins extend beyond the line angle and the incisal angle is involved.

3.2.4.3 Multiple Restorations, Amalgams, and Resin Restorations – Rule 12/01/1998

Multiple restoration of the same surface of tooth is allowed as a single surface in posterior teeth. Anterior teeth numbers 6 through 11 and 22 through 27 may have same surfaces involved. Reimbursement for pit restoration is allowed as a one-surface restoration.

Adhesives, bases, and polishing amalgams are included in the allowance for the major restoration.

Amalgams and resin restorations will be covered once in a two-year period, same tooth, same surface. Liners and bases are included as part of the restoration. If pins are used, they should be reported separately. If this surface is redone with an additional adjoining surface, all restored surfaces will be covered. Replacement within a two-year period may be authorized with justification.

3.2.4.4 Crowns – Rule 12/01/1998

Cast crowns and laboratory resin crowns are limited to once in a two year period for the same tooth. When submitting for prior authorization, either an x-ray showing the root canal or an x-ray with a justification detailing the reason for the crown is required.

Prefabricated crowns are not limited to the two year replacement policy.

Prosthodontics, fixed, procedure codes 06210 through 06920 are not Medicaid covered benefits.

Service	Dental Code	Description	Effective Rule Date
AMALGAM RESTORATIONS			
	02110	Amalgam — one surface, primary. Tooth and surface designations required.	12/01/1998
	02120	Amalgam — two surfaces, primary. Tooth and surface designations required.	12/01/1998
	02130	Amalgam — three surfaces, primary. Tooth and surface designations required.	12/01/1998
	02131	Amalgam — four or more surfaces, primary. Tooth and surface designations required.	12/01/1998
	02140	Amalgam — one surface, permanent. Tooth and surface designation required.	12/01/1998
	02150	Amalgam — two surfaces, permanent. Tooth and surface designation required.	12/01/1998
	02160	Amalgam — three surfaces, permanent. Tooth and surface designation required.	12/01/1998
	02161	Amalgam — four or more surfaces, permanent. Tooth and surface designation required.	12/01/1998
RESIN RESTORATIONS: Allowed once every two years, same tooth, same surface. Resin refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Light-curing, acid-etching, and adhesives (including resin bonding agents) are part of the restoration. Report glass ionomers with these codes when used as restorations. If pins are used, report them separately.			
	02330	Resin — one surface, anterior. Tooth and surface designations required.	12/01/1998
	02331	Resin — two surfaces, anterior. Tooth and surface designations required.	12/01/1998

Service	Dental Code	Description	Effective Rule Date
	02332	Resin — three surfaces, anterior. Tooth and surface designations required.	12/01/1998
	02335	Resin — four or more surfaces or involving incisal angle, anterior. Tooth and surface designations required.	12/01/1998
	02380	Resin — one surface, posterior — primary. Tooth and surface designations required.	12/01/1998
	02381	Resin — two surfaces, posterior — primary. Tooth and surface designations required.	12/01/1998
	02382	Resin — three or more surfaces, posterior — primary. Tooth and surface designations required.	12/01/1998
	02385	Resin — one surface, posterior — permanent. Tooth and surface designations required.	12/01/1998
	02386	Resin — two surfaces, posterior — permanent. Tooth and surface designations required.	12/01/1998
	02387	Resin — three or more surfaces, posterior — permanent. Tooth and surface designations required.	12/01/1998
CROWNS			
	02710	Crown resin (laboratory). Tooth designation required. Not allowed in primary teeth.	12/01/1998
	02721	Crown resin with predominantly base metal. Not allowed in primary teeth.	12/01/1998
	02751	Crown porcelain fused to predominantly base metal. Tooth designation required. Not allowed in primary teeth.	12/01/1998
	02791	Crown full cast predominantly base metal. Tooth designation required. Not allowed in primary teeth.	12/01/1998
OTHER RESTORATIVE SERVICES			
	02920	Recement crown. Tooth designation required.	12/01/1998
	02930	Prefabricated stainless steel crown — primary tooth. Tooth designation required.	12/01/1998
	02931	Prefabricated stainless steel crown — permanent tooth. Tooth designation required.	12/01/1998
	02932	Prefabricated resin crown. Tooth designation required.	12/01/1998
	02940	Sedative filling. Tooth designation required. Surface is not required.	12/01/1998
	02950	Core buildup, including any pins. Tooth designation required. Limited to two pins per tooth.	12/01/1998
	02951	Pin retention — per tooth, in addition to restoration. Tooth designation required. Limited to two pins per tooth.	12/01/1998
	02954	Prefabricated post and core in addition to crown.	12/01/1998
	02955	Post removal.	12/01/1998
	02980	Crown repair. Tooth designation required. .	12/01/1998
	02999	Unspecified restorative procedure, by report. Narrative and tooth designation required when prior authorizing.	12/01/1998

3.2.5 Endodontics 03000 — 03999 – Rule 12/01/1998

Pulpotomies and root canal procedures cannot be paid with the same date of service for the same tooth.

Service	Dental Code	Description	Effective Rule Date
PULP CAPPING			
	03110	Pulp cap — direct (excluding final restoration). Tooth designation required.	12/01/1998
PULPOTOMY			
	03220	Therapeutic pulpotomy (excluding final restoration). Once per tooth. Tooth designation required.	12/01/1998
ROOT CANAL THERAPY: Pulpectomy is part of root canal therapy. Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/ diagnostic images. Root canal therapy (includes treatment plan, x-rays, clinical procedures and follow-up care) for permanent teeth only. Separate charges are allowable for open and drain if the procedure is done on different days. Root canal procedures are limited to permanent teeth.			
	03310	Anterior (excluding final restoration). Tooth designation required.	12/01/1998
	03320	Bicuspid (excluding final restoration). Tooth designation required.	12/01/1998
	03330	Molar (excluding final restoration). Tooth designation required.	12/01/1998
APICOECTOMY/PERIRADICULAR SERVICES			
	03410	Apicoectomy/Periradicular surgery-anterior surgery or root of anterior tooth. Does not include placement of retrograde filling material. Tooth designation required.	12/01/1998
	03421	Apicoectomy/Periradicular surgery-bicuspid (first root). Surgery on one root of a bicuspid does not include placement of retrograde filling material. Tooth designation required.	12/01/1998
	03425	Apicoectomy/Periradicular surgery-Molar (first root). Does not include placement of retrograde filling material. Tooth designation required.	12/01/1998
	03426	Apicoectomy/Periradicular surgery (each additional root). For molar surgeries when more than one root is being treated during the same procedure. Does not include retrograde filling material placement. Tooth designation required.	12/01/1998
	03430	Retrograde filling - per root. For placement of retrograde filling material during Periradicular surgery procedures. Tooth designation required.	12/01/1998
	03999	Unspecified restorative procedure, by report. Narrative and tooth designation required when prior authorizing.	12/01/1998

3.2.6 Periodontics 04000 — 04999 – Rule 12/01/1998

Service	Dental Code	Description	Effective Rule Date
SURGICAL SERVICES			
	04210	Gingivectomy or gingivoplasty — quadrant. Quadrant designation required.	12/01/1998
	04211	Gingivectomy or gingivoplasty — per tooth. Tooth designation required.	12/01/1998
	04220	Gingival curettage, surgical, per quadrant. Designate quadrant.	12/01/1998
ADJUNCTIVE PERIODONTAL SERVICES			
	04320	Provisional splinting - intracoronal..	12/01/1998
	04321	Provisional splinting - extracoronal.	12/01/1998
	04341	Periodontal scaling and root planing (per quadrant). Allowed once in a 12-month period. This procedure is indicated for clients with periodontal disease and is therapeutic, not prophylactic, in nature. Quadrant designation required.	12/01/1998
	04355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis. Allowed once in a 12-month period. There should be no waiting period between services rendered using this procedure code and procedure code 01110 and 01120, however, they cannot be done on the same day. The removal of subgingival and supragingival plaque and calculus obstructs the ability to perform an oral evaluation. This is a preliminary procedure and does not preclude the need for other procedures.	12/01/1998
OTHER PERIODONTAL SERVICES			
	04910	Periodontal maintenance procedures (following active therapy - 04341). Allowed once in a three-month period. This procedure is for clients who have completed periodontal treatment (surgical and adjunctive periodontal therapies exclusive of 04355) and includes removal of the bacterial flora from crevicular and pocket areas, scaling and polishing of the teeth and a review of the client's plaque control efficiency.	12/01/1998
	04999	Unspecified periodontal procedure. Narrative required when prior authorizing.	12/01/1998

3.2.7 Prosthodontics 05000 — 06999 – Rule 12/01/1998

3.2.7.1 Removable Prosthodontics 05000 — 05899 – Rule 12/01/1998

The Medicaid dental program covers only one set of dentures in a five-year period. Dentures placed immediately must be of structure and quality to be considered the final set. Transitional or interim treatment dentures are not covered. No additional reimbursements are allowed for denture insertions.

Partial dentures are limited to age 12 and older.

When inserted during a month when the client is not eligible, but other work, including laboratory work, is completed during an eligible period, the claim for the dentures is allowed. Use the impression date, not the seating date, as the service date.

Medicaid pays for partial dentures once every five years. One partial per arch is covered. When a partial is inserted during a month when the client is not eligible but all other work, including laboratory work, is completed during an eligible period, the claim for the partial is allowed. Use the impression date as the date of service.

Laboratory and professional fees may be paid for a partial or complete denture if the client:

- Decides not to complete the partial or complete denture
- Leaves the state
- Cannot be located
- Expires

An invoice listing lab and professional fees is required when prior authorizing.

Service	Dental Code	Description	Effective Rule Date
COMPLETE DENTURES: This includes six months of adjustments following placement.			
	05110	Complete denture — maxillary.	12/01/1998
	05120	Complete denture — mandibular.	12/01/1998
	05130	Immediate denture — maxillary.	12/01/1998
	05140	Immediate denture — mandibular.	12/01/1998
	0515D	Unable to deliver full denture. Laboratory cost may be paid for full dentures if the client: a. decides not to complete the denture b. leaves the state c. cannot be located d. expires An invoice listing lab and professional fees required when prior authorizing.	12/01/1998
PARTIAL DENTURES: This includes six months of care following placement. Limited to 12 years and older.			
	05211	Maxillary partial denture — resin base. Includes any conventional clasps, rests, and teeth.	12/01/1998
	05212	Mandibular partial denture — resin base. Includes any conventional clasps, rests, and teeth.	12/01/1998
	05213	Maxillary partial denture — cast metal framework with resin denture bases. Includes any conventional clasps, rests, and teeth.	12/01/1998
	05214	Mandibular partial denture — cast metal framework with resin denture bases. Includes any conventional clasps, rests, and teeth.	12/01/1998
ADJUSTMENTS TO COMPLETE AND PARTIAL DENTURES: No allowance for adjustments for six months following placement. Adjustments done during this period are included in complete/partial allowance.			
	05410	Adjust complete denture — maxillary.	12/01/1998
	05411	Adjust complete denture — mandibular.	12/01/1998
	05421	Adjust partial denture — maxillary.	12/01/1998
	05422	Adjust partial denture — mandibular.	12/01/1998
REPAIRS TO COMPLETE DENTURES			
	05510	Repair broken complete denture base.	12/01/1998
	05520	Replace missing or broken teeth — complete denture (each tooth) — six tooth maximum. Tooth designation required.	12/01/1998
REPAIRS TO PARTIAL DENTURES			
	05610	Repair resin denture base. Arch designation required.	12/01/1998
	05620	Repair cast framework. Arch designation required.	12/01/1998
	05630	Repair or replace broken clasp. Arch designation required.	12/01/1998
	05640	Replace broken teeth, per tooth. Tooth designation required.	12/01/1998
	05650	Add tooth to existing partial denture. Does not involve clasp or abutment tooth. Tooth designation required.	12/01/1998
	05660	Add clasp to existing partial denture. Involves clasp or abutment tooth.	12/01/1998